77 Great Road (Route 2A)
Suite 203
Acton, MA 01720
Phone 978.263.5771/Fax 978.263.57
info@bewellandbeyond.com

Acupuncture Patient Consent Form

PLEASE INITIAL EACH STATEMENT AFTER READING IT

- I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below-named licensed acupuncturist.
- I understand that methods or treatments may include, but are not limited to, acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Chinese herbal medicine and nutritional counseling.
- I understand that acupuncture, with or without herbs, is not meant to replace conventional biomedicine, should my case warrant it. I further understand that any Western diagnosis of my condition must be performed by a licensed physician and that I shall be responsible for consulting with the necessary physician(s). I further understand that **Be Well and Beyond** makes no claim about curing my condition.
- I understand that **Be Well and Beyond** will take all possible measures to keep my personal information confidential. May it be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and /or to share appropriate medical information, my signature gives my practitioner permission to release my medical records for the reasons listed above.
- I agree to have **Be Well and Beyond** contact me over the phone or by e-mail about appointment time(s).
- I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.
- I agree to pay full charge for any missed or forgotten appointments without 24 hours notice of cancellation.
- I agree to pay full charges incurred for services rendered, over and above insurance coverage.

____
Patient's Name

____
Patient's Signature

____
Date Signed

____
***Be Well and Beyond* Practitioner Name**

____
***Be Well and Beyond* Practitioner Signature**

____
Date Signed

To be completed by the patient's representative, if the patient is a minor or is physically or legally incapacitated.
  Name of Patient
  Patient's Representative
  Relationship or Authority to Patient
  Witness

2013

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NOTICE OF PRIVACY PRACTICE SUMMARY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

***Be Well and Beyond, Inc*.,** in accordance with applicable federal and state law, is committed to maintaining the privacy of your Protected Health Information (PHI), information about your health condition and the care and treatment you receive. We will use and disclose elements of your PHI in the following way:

- Treatment
- Payment
- Healthcare Operations
- When release is required by law, including judicial settings, and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or help in their duties.
- To organ, tissue, and other donation organization, upon or proximate to your death, if we have no indication on hand about your donation preferences.
- Appointment reminders, treatment alternatives, and other related benefits and services.
- Sponsor of Your Health Plan

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

YOUR RIGHTS - You have the following rights concerning your PHI:

- **We will obtain an authorization from you before using or disclosing**: PHI in a way that is not described in this Notice.
- **Right to Be Notified if There is a Breach of Your Unsecured PHI.** (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.
- **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket.** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.
- **Restrictions** (to request restricted access to all or part of your PHI). To do this, please make this request in writing. We are not required to grant your request.
- **Confidential Communications** (to receive correspondence of confidential information by alternate means or location). To do this, please make a request in writing.
- **Access** (to inspect or to receive copies of your PHI). To do this, please submit a request in writing.
- **Amendment** (to request changes be made to your PHI). Please submit a request in writing.
- **Accounting** (to receive an accounting of disclosure by us of your PHI in the six years prior to your request). To do this, please submit a request in writing.
- **This Notice** (to get updates or reissue of this notice). At your request.
- **Complaints** (to complain to our office or the US Department of Health & Human Services, if you feel your privacy rights have been violated). To register a complaint with us, please submit this request in writing. The law forbids us from taking retaliatory action against you if you complain.

OUR DUTIES. We are required by law to maintain the privacy of your PHI. We must abide by the term of this notice or any update of this notice.

Privacy Contact: To obtain additional information on or have your questions about your rights answered, you may contact ***Be Well and Beyond, Inc*.,** 77 Great Road, Acton, MA 01720.

Effective Date: September 23, 2013. A complete copy of the Notice of Privacy Act is available.

Acknowledgement of Receipt ____ Date ________________________________